

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN0502	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/21/2010
NAME OF PROVIDER OR SUPPLIER COLONIAL HILLS NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2034 COCHRAN RD MARYVILLE, TN 37803		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
N 000	Initial Comments During complaint investigation numbers TN00025370, TN00024811, TN00025371, TN00025376, conducted on April 21, 2010, at Colonial Hills Nursing Center, no deficiencies were cited in relation to the complaint under chapter 1200-8-6, Standards for Nursing Homes.	N 000			

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *[Signature]* TITLE *[Signature]* (X6) DATE *5/1/2010*

STATE FORM 6899 6VJ511 If continuation sheet 1 of 1

MAY 10 2010